STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365539	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Nursing & Rehab	2473 North Rd NE Warren, OH 44483

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on review of the medical record, interview, and review of the facility policy the facility failed to ensure Resident #80 received an indwelling urinary catheter upon physician recommendation, failed to ensure appropriate care and services related to indwelling urinary catheters were in place when Resident #80 returned to the facility, failed to ensure Resident #80 was free from complications related to the indwelling urinary catheter, and failed to ensure complications were followed-up on timely and appropriately. This affected one resident (Resident #80) of three residents who were reviewed for appropriate care and services related to urinary catheters and urinary tract infections. The facility census was 77. Findings include: Review of the medical record for Resident #80 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included stage four chronic kidney disease, liver disease, heart failure, neutropenia, pancytopenia, atrial fibrillation, chronic obstructive pulmonary disease (COPD), and vascular dementia. Further review of the medical record revealed Resident #80 was hospitalized from 06/06/24 through 06/18/24. Additional diagnoses added post-hospitalization on [DATE] included acute cystitis without hematuria, sepsis, cellulitis of groin, dysphagia, and candidiasis of skin and nail. Review of the discharge with return anticipated Minimum Data Set (MDS) 3.0 assessment completed on 06/06/24 revealed Resident #80 required modified independence for daily decision-making and was dependent on staff for activities of daily living (ADL). Resident #80 was always incontinent of bladder and bowel and had no indwelling urinary catheter. Review of the SPECIALY PHYSCIAN WOUND EVALUATION & MANAGEMTN SUMMARY completed on 05/30/24 revealed Wound Care Physician #253 recommended that Resident #80 trial the use of an indwelling urinary catheter because Resident #80's sacral and groin wounds were deteriorating and listed as exacerbated due to multifactorial causes, which included Resident #80 refused dressing changes and personal hygiene care. Review of the progress notes from 05/30/24 through 06/06/24 revealed no mention of attempts to obtain an order or place an indwelling urinary catheter per the wound physician's recommendations. Review of Resident #80's care plan last updated on 06/18/24 revealed no care plan related to the presence of an indwelling urinary catheter or catheter care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 06/18/24 at 1:58 P.M. revealed Resident #80 returned to the facility from the hospital with an indwelling urinary (Foley) catheter intact and draining yellow, non-odorous urine. Review of the readmission assessment completed on 06/19/24 at 10:18 A.M. revealed Resident #80 had an indwelling 16 French urinary catheter to prevent soiling of a Stage III (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) or Stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling) pressure ulcers. Review of the linked progress note revealed the same information related to Resident #80 having an indwelling urinary catheter in place. Review of the note dated 06/26/24 at 6:07 A.M. revealed Registered Nurse (RN) #213 noted an open skin area on the bottom left labia, yellowish-white vaginal discharge, and a lot of pain when inserting a new indwelling urinary catheter. Further review of the progress notes revealed no notes indicating follow-up related to the skin alteration, vaginal discharge, or increased pain with catheter insertion. Review of the weekly skin assessment completed 06/26/24 did note a new skin area to Resident #80's left lower inner labia with vaginal drainage. The area of the note regarding physician or nurse practitioner (NP) notification, family or resident representative notification, and wound alert creation were all left blank (not check-marked). The only wound assessment completed after the identification of labial tear was completed on 06/28/24 for wounds on the left groin and the sacrum. The medical record contained no further assessment or mention of the labial tear and discharge. Review of the physician orders from 04/11/24 through 06/30/24 revealed the following indwelling urinary catheter-related orders dated 06/28/24 (there were no indwelling urinary catheter-related orders prior to this date): Indwelling urinary (Foley) catheter #18 French, five to ten cubic centimeter (cc) volume, to continuous drainage every shift for wound care. Catheter care per policy every shift, change Foley catheter as needed, change Foley catheter bag as needed, change Foley graduate (urine collection device for drainage from the catheter drainage bag) on night shift once a month beginning on the fifth of every month, Foley catheter strap to leg at all times, and privacy bag every shift. Interview on 10/02/24 at 3:00 P.M. with Unit Manager #127 confirmed Resident #80 had returned from her last hospitalization (inpatient from 06/06/24 to 06/18/24) with an indwelling urinary catheter. Unit Manager #127 further confirmed Resident #80, to her recollection, continued to have an indwelling urinary catheter in place as she transitioned to Hospice services until the time of her death/discharge on 06/30/24. Interview on 10/07/24 at 9:48 A.M. with the Director of Nursing (DON) confirmed Resident #80 had no indwelling urinary catheter orders or record of daily catheter monitoring or care prior to 06/28/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview on 10/07/24 at 10:23 A.M. with the DON confirmed Resident #80 did not have an indwelling urinary catheter inserted between 05/30/24 and her transfer to the hospital on 06/06/24 and that Resident #80 had an indwelling urinary (Foley) catheter inserted on 06/08/24 while in the hospital. The DON also confirmed Resident #80 returned to the facility on [DATE] with an indwelling urinary catheter in place and continued to have an indwelling urinary catheter through the duration of her facility stay. She also verified there was no documented evidence of physician and/or family notification of the labial tear and vaginal discharge identified on 06/26/24. Review of policy from the September 2014 edition of MED-PASS titled Catheter Care, Urinary revealed a resident with a urinary catheter was to have urine output observed for noticeable increases or decreases. The catheter and drainage system were to be inserted, maintained, and replaced as ordered. The policy further revealed residents with catheters were to be observed for complications, including feelings of bladder fullness, unusual appearance of the urine, bleeding, accidental removal, and complaints of burning, tenderness, or pain. This deficiency represents non-compliance investigated under Complaint Number OH00158051.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, review of the medical record, and review of the facility policy the facility failed to ensure the medication error rate was below five percent (%) when two medication errors occurred during 26 medication administration opportunities, resulting in a medication error rate of 7.69%. This affected one resident (Resident #32) of ten residents who were reviewed for medication administration. The facility census was 77. Findings include: Review of the medical record for Resident #32 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), chronic embolism and thrombosis, morbid obesity, hyperlipidemia, congestive heart failure, major depressive disorder, stage three chronic kidney disease, acute respiratory failure, and chronic gout. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 09/20/24 revealed Resident #32 was cognitively intact with a primary medical condition categorized as debility and cardiorespiratory conditions. Resident #32 was on a scheduled pain regimen and received medications from the following high risk drug classes: antidepressants, anticoagulants, diuretics, and opioids. Review of the physician orders revealed an order dated 02/29/24 for Fluticasone Propionate Suspension (steroid) 50 micrograms per actuation (mcg/ACT), two sprays in each nostril each morning for seasonal allergies. Further review if the orders dated 02/29/24 revealed Resident #32 was to receive folic acid (vitamin) 1 milligram (mg) by mouth in the mornings. Observation of medication administration on 10/07/24 at 8:35 A.M. revealed Licensed Practical Nurse (LPN) #255 administered the scheduled morning medications to Resident #32 except for the following two ordered medications: 1) Fluticasone Propionate suspension 50 mcg/ACT, two sprays in each nostril each morning for seasonal allergies and 2) folic acid 1 mg by mouth in the morning. Review of the medication administration record (MAR) for October 2024 revealed the folic acid and Fluticasone Propionate were coded 9 (Other/See Progress Notes) for the morning medication pass on 10/07/24. Review of the progress notes revealed notes dated 10/07/24 indicating Resident #32 did not receive Fluticasone Propionate nasal spray or folic acid as ordered for reason listed as N/A or not available. Interview on 10/07/24 at 8:43 A.M. with LPN #255 confirmed Resident #32 was supposed to receive two sprays into each nostril of Fluticasone Propionate suspension each morning and folic acid 1 mg by mouth each morning, but neither were available to administer. LPN #255 confirmed at this time that folic acid was in the facility stock; however, it was not the correct dose (it was 400 mcg). LPN #255 further confirmed when she attempted to reorder the folic acid in the correct strength, it was not an available option in the electronic ordering system, but she was able to reorder the Fluticasone Propionate suspension nasal spray. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Administering Medications, last revised April 2019, revealed medications were to be administered in accordance with the prescriber's orders, which included administration of medications within the ordered timeframe. This deficiency represents non-compliance investigated under Master Complaint Number OH00158489.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, medical record review, and review of the facility policy the facility failed to ensure enhanced barrier precautions (EBP) were maintained while tracheostomy, ventilator, and feeding tube related care were performed by multiple staff members. This affected one resident (Resident #73) of three residents who had tracheostomies and who were observed during the administration of medications or procedures. The facility census was 77. Findings include: Review of the medical record for Resident #73 revealed an original admitted [DATE] and a re-entry date of 07/17/24. Diagnoses included epilepsy, acute and chronic respiratory failure, congestive heart failure, muscular dystrophy, chronic obstructive pulmonary disease (COPD), neuromuscular dysfunction of bladder, anxiety disorder, sepsis, ileus, tracheostomy status, and attention to gastrotomy. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 09/09/24 revealed Resident #73 had intact cognition and was dependent on staff for activities of daily living. Resident #73 had an indwelling urinary catheter, unhealed Stage III (full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) or Stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling) pressure ulcers, a feeding tube, and required tracheostomy care, suctioning, and invasive mechanical ventilation. Review of the physician's orders for Resident #73 revealed an order dated 07/18/24 for EBP related to tracheostomy, percutaneous endoscopic gastrostomy (PEG) tube (a feeding tube inserted into the stomach for nutrition and/or medication), candida aureus, suprapubic catheter, wound, pseudomonas aeruginosa, and Acinetobacter baumannii. Review of the care plan dated 06/06/24 revealed Resident #73 had the need for EBP related to an increased risk for multidrug-resistant organism (MDRO) infections due to indwelling medical devices and wound status. Interventions included to don appropriate personal protective equipment (PPE) prior to providing high-contact resident care and for device care or use, including urinary catheter, PEG tube, wound, and tracheostomy or ventilator care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/03/24 from 5:25 P.M. to 5:35 P.M. revealed Licensed Practical Nurse (LPN) #254 prepared medication for PEG tube administration, entered the room of Resident #73, placed the mediation and water on the bedside table, donned gloves (no gown), then proceeded to disconnect the ventilator tubing and drain the condensation out of the tubing before reconnecting the ventilator tubing. Ongoing observation revealed LPN #254 then provided tracheal suctioning and informed Resident #254 she would get the respiratory therapist (RT) to come and assess his respiratory status further. LPN #254 removed her gloves, washed her hands, picked up the medication cups, and continued down the hall to request that RT #185 assess Resident #73 and perform cough assist treatments (a procedure that uses a machine to help clear chest secretions by simulating a natural cough) per the resident's request. During this time, LPN #254 was also observed briefly entering a resident's room at the other end of the hallway in response to an activated call light while still carrying Resident #73's prepared medication. Observation on 10/03/24 from 5:35 P.M. to 5:40 P.M. revealed RT #185 changed a piece of the ventilator tubing for Resident #73 and performed tracheal suctioning with no gown. Further observation revealed RT Student #257 performed cough assist treatments, changed the ventilator tubing again, and suctioned his tracheostomy with gloves but no gown. During this observation, RT #185 held the old ventilator tubing in the air, filled with thick mucus, waved it in a left to right motion several times, while urging Resident #73 to look at the mucus-filled tubing as an example of how mucus gets plugged in his airway when there is not enough humidification. RT #18 did this while wearing no gloves or gown. Observation on 10/03/24 from 5:42 P.M. to 5:50 P.M. revealed LPN #254 administered medication and water flushes to Resident #73 via the PEG tube. LPN #254 removed the saturated PEG tube dressing, discarded it in the trash can, cleaned the stoma, applied medicated cream, and a new dry split-gauze dressing to the PEG tube site. During this observation, LPN #254 wore gloves but not a gown and was noted to have to lean against Resident #73's bed linen to perform the medication administration and PEG tube care. Interview on 10/03/24 at 5:53 P.M. with LPN #254 confirmed she did not wear a gown to empty the condensation on Resident #73's ventilator tubing, administer his pain medication and water flushes, remove the saturated PEG tube split gauze dressing, or perform PEG site care. During the interview, LPN #254 also confirmed that RT #185 and RT Student #257 performed ventilator tubing changes, cough assist treatment, and suctioning without donning gowns. Interview on 10/03/24 at 6:10 P.M. with LPN #152 confirmed when a resident had orders for EBP, all care requiring direct contact with that resident required staff to wear a gown and gloves. LPN #152 further confirmed Resident #73 was placed in EBP, and a gown and gloves should have been worn to provide care involving high contact care or care pertaining to any medical devices, which included his tracheostomy, PEG tube, and ventilator. Review of the facility policy titled Enhanced Barrier Precautions, updated on 09/27/24, revealed nursing home residents with wounds and indwelling medical devices were high risk for the acquisition and/or colonization of multidrug-resistant organisms (MDROs) and the use of a gown and gloves for high-contact resident care activities for nursing home residents with wounds or indwelling medical devices was indicated regardless of the presence of an MDRO. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Center for Clinical Standards and Quality/Quality, Safety & Oversight (QSO) Group memorandum summary, reference number QSO-24-08-NH, issued 03/20/24, revealed EBP in long-term care facilities became effective on 04/01/24 to align with nationally accepted standards. The QSO memorandum further revealed EBP was to include residents with chronic wounds and/or indwelling medical devices, including feeding tubes and tracheostomies, during high contact care regardless of their status related to multidrug-resistant organisms. This deficiency represents non-compliance investigated under Complaint Number OH00157581.